Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING _____ B. WING _____	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAM N WISHARD MEMORIAL HOSPITAL	1001 W 10TH ST INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for 2 (two) State hospital complaint investigations. Complaint: #IN00077155 Unsubstantiated; lack of sufficient evidence. Complaint: #IN00084566 Unsubstantiated; lack of sufficient evidence. Facility: #005023 Date: 7/18/2011 & 7/19/2011 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor William N. Wishard Memorial Hospital is in compliance with 410 IAC 15-1.6.2, Emergency services and 410 IAC 15-1.6.8, Surgical services, Indiana State Hospital Licensure Rules. QA: claughlin 08/01/11	S 000		